STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 01 B. WING	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/19/13 Facility Number: 000305 Provider Number: 155625 AIM Number: 100287200 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Arbor Grove Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility	K010000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	has a capacity of 89 and had a census of 65 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/22/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 107 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects 22 residents who reside on the North 400 Hall. Findings include: Based on observations on 02/19/13 during a tour of the facility from 9:20 a.m. to 1:40 p.m. with the maintenance supervisor, the corridor doors to the Service Hall kitchen and the North 400 Hall medicine room each had between a one half inch and one inch gap along the top and latching sides of the doors. Furthermore, both room doors failed to	K010018	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe doors have been repaired by the Maintenance Director and now have no issues with gapping or latching.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice. The doors were repaired by the Maintenance Director and now have no issues with gapping or latching. All doors were inspected and no others identified as having issues.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurRoutine rounds will	03/08/2013

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	latch into the door frame. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b)		be conducted to ensure that all doors appropriate close and latch without gapping by the Maintenance Director and/or designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored through the monthly fire drills and the environment CQI conducted monthly for 6 months to ensure that all doors properly close and latch without gapping. Any issues identified during the routine monitoring will be addressed timely by the Maintenance Director and/or designee. This will be reviewed by the Quality Assurance Committee and action plans developed for any area lower than 90%.	

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K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 5 of 107 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 30 residents who reside on the 400 Hall. Findings include: Based on observations with the maintenance supervisor on 02/19/13 during a tour of the facility from 9:20 a.m. to 1:40 p.m., the following ceiling and room smoke barriers were not fire stopped; a. The 400 Center Hall video room ceiling had a one inch gap around a cable bundle with no fire stopping material. b. The 400 Center Hall soiled linen room	K010025	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceAll smoke barriers were corrected so that each area identified is now fire stopped by the Maintenance Director.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice. Rounds were conducted to ensure that all smoke barriers are appropriately fire stopped. No other areas identified.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurRoutine rounds will be conducted by the Maintenance Director and/or designee to ensure that all smoke barriers are properly fire stopped. All areas identified during rounds will be addressed timely by the	03/08/2013

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	west wall under the sink had a two foot by one foot area of drywall missing around the plumbing. c. The 400 Hall activity mechanical room west wall had a one inch gap around an electrical conduit with no fire stopping material. d. The 400 Hall activity mechanical room ceiling had a one inch gap around a square metal air return duct which was not firmly affixed to the ceiling. e. The 400 Hall ice machine room east wall had a one inch gap around the ice machine water supply line with no fire stopping material. f. The 400 Hall activity storage room east wall had a one inch gap around three capped off water pipes with no fire stopping material. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b)		Maintenance Director and/or designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored through the environmental CQI on a monthly basis for six months. It will be reviewed by the Quality Assurance team. An action plan will be developed for any area with a threshold lower than 90%. All areas identified on the environmental CQI will be addressed timely by the Maintenance Director.	

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K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 30 residents who reside on 400 Hall. Findings include: Based on observation with the maintenance supervisor on 02/19/13 at 1:10 p.m., the 400 Hall dining room set of smoke barrier doors had a three inch gap between the doors in the closed position. This was verified by the maintenance	K010027	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe actuator was repaired by the Maintenance Director so that the smoke barrier doors close without gapping.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice. The coordinator was repaired by the Maintenance Director so that the smoke barrier doors close without gapping. All other smoke barrier doors were inspected, and no others identified as having issues.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurSmoke barrier doors will be inspected during monthly fire drills to ensure proper functioning without gapping by the Maintenance Director and/or	03/08/2013

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	supervisor at the time of observation and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b)		designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored through the monthly fire drills and the Environment CQI monthly for 6 months. This will be reviewed monthly by the Quality Assurance Committee, and action plans will be developed for areas under 90%. All issues identified through monitoring will be addressed timely by the Maintenance Director and/or designee.	

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 8 storage rooms measuring over 50 square feet in size used for storage of combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 20 residents who reside on the 100 Hall. Findings include: Based on observation on 02/19/13 at 1:20 p.m. with the maintenance supervisor, the door to 100 Hall nurses storage room which measured ninety six square feet and had combustible storage consisting of eight plastic bed mattresses, lacked a self closing device. This was verified by the maintenance supervisor at the time of observation and confirmed by the	K010029	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceA self closing device was installed on the door to the storage area affected by the alleged deficient practice by the Maintenance Director.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be identified by the alleged deficient practice.A self closing device was installed on the door to the storage area affected by the alleged deficient practice by the Maintenance Director. All other areas were inspected, and no others were identified as being affected.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurAll areas were inspected to ensure that	03/08/2013

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	administrator at the exit conference on 02/19/13 at 2:00 p.m. 3.1-19(b)		areas requiring a self closing device were in compliance. No other areas were identified. Routine rounds will be conducted to ensure that all areas requiring a self closing device will have those devices installed if not currently in place by the Maintenance Director and/or designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored through the Environmental CQI monthly for 6 months. It will be reviewed by the Quality Assurance Committee and any areas below 90% will have an action plan developed.	

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K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 6 corridors converted to quick response sprinklers was equipped throughout with quick response sprinklers which operate in a timely manner and achieve effective fire control. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, 5-1.1 states the requirements for spacing, location, and position of sprinklers shall be based on the following principles: (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect 18	K010056	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe quick response sprinklers were ordered and will be installed by PIPE inc, the sprinkler vendor and supervised by the Maintenance Director and/or designee.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice.The sprinklers were inspected by the Maintenance Director and PIPE inc to ensure that all areas had the appropriate sprinkler heads in place. No other areas were identified as needing addressed.what measures will be put into place or what systemic changes will be	03/21/2013

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	residents who reside on 300 Hall. Findings include: Based on observations on 02/19/13 during a tour of 300 Hall from 12:20 p.m. to 1:15 p.m. with the maintenance supervisor, the 300 Hall corridor had thirteen Ordinary rated sprinklers and three Quick Response rated sprinklers in the same location. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 02/19/13 at 2:00 p.m. 3.1-19(b)		made to ensure that the deficient practice does not recurDuring required quarterly sprinkler inspections, the vendor will inspect all sprinklers to ensure that all appropriate sprinkler heads are in place. This will be supervised by the Maintenance Director. All areas identified as requiring further action during the inspection, will be immediately corrected.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored during quarterly routine sprinkler inspections by the sprinkler vendor and overseen by Maintenance Supervisor.	

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K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper quick response sprinkler wasn't available as a replacement. Findings include: Based on observations on 02/19/13 during the tour of the facility from 9:20 a.m. to 1:40 p.m. with the maintenance	K010062	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe red liquid quick response sprinklers were ordered and will be in stock in the facility by 3/21/13 by the Maintenance Director.The gaps around the sprinkler excushion were repaired by the Maintenance Director.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice.The red liquid quick response sprinklers were ordered and will be in stock in the facility by 3/21/13 by the Maintenance Director. The gaps around the sprinkler excushions were repaired by the Maintenance Director. The facility was inspected, and no other sprinkler excushions were identified.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurDuring routine quarterly sprinkler inspections, the sprinkler head stock will be reviewed for adequate supply of all necessary	03/21/2013

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	supervisor, red liquid filled quick response sprinklers with a temperature rating of 145 degrees F were observed in the 100 Hall corridor, 200 Hall corridor, 300 Hall corridor, and the 400 Hall corridor. Based on observation of the spare sprinkler cabinet located in the 200 Hall sprinkler riser room on 02/19/13 at 11:50 a.m. with the maintenance supervisor, there were no red liquid filled quick response sprinklers in the spare sprinkler cabinet. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 2 residents who reside in resident room 413 and 2 residents who reside in resident room 309. Findings include: Based on observations on 02/19/13 during a tour of the facility with the maintenance supervisor from 9:20 a.m. to 1:40 p.m., the bathroom sprinkler head escutcheon in resident room 413 and the sprinkler head		sprinkler heads by the Maintenance Director and/or designee. The sprinkler excushions will be inspected during quarterly sprinkler inspections to ensure proper fitting and routine rounds will be completed by the Maintenance Director and/or designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeDuring routine quarterly sprinkler inspections, the sprinkler head stock will be reviewed for adequate supply of all necessary sprinkler heads by the Maintenance Director and/or designee. Insufficient supplies will be addressed immediately by the Maintenance Director and/or designee. The sprinkler excushions will be inspected during quarterly sprinkler inspections to ensure proper fitting and routine rounds will be completed by the Maintenance Director and/or designee.	

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	155625	A. BUILDING 01 B. WING	02/19/2013

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	escutcheon near bead 1 in resident room 309 were not flush to the ceiling leaving a one half inch gap into the attic space above. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b) 3.			

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K010067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 7 of 7 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a potion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility. Findings include: Based on observations on 02/19/13 during a tour of the facility from 9:20 a.m. to 1:40 p.m. with the maintenance supervisor, all rooms in the facility used the egress corridors as a return air system. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the 2:00 p.m. exit conference on 02/19/13. 3.1-19(b)	K010067	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice2 of the 4 resident room wings are corrected and in compliance with return air vents in the rooms. The other 2 allegedly affected resident room wings will be corrected by April 30, 2013 by Phoenix Refrigeration. The supplies for the remainder of the project have been ordered by Phoenix Refrigeration and should arrive within 30 days of 3/8/13 so that work can begin and be completed by the projected completion date.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice. 2 of the 4 resident room wings are corrected and in compliance with return air vents in the rooms. The other 2 allegedly affected resident room wings will be corrected by April 30, 2013 by Phoenix Refrigeration. The supplies for the remainder of the project have been ordered by Phoenix Refrigeration and should arrive within 30 days of 3/8/13 so that	04/30/2013

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			work can begin and be completed by the projected completion date. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recurBy April 30, 2013, all rooms will have return air vents and no longer rely on the egress corridor as a return air system. This project will be completed by Phoenix Refrigeration. It will also be maintained and serviced by Phoenix Refrigeration and the Maintenance Director and/or designee on a routine basis to ensure compliance.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeBy April 30, 2013, all rooms will have return air vents and no longer rely on the egress corridor as a return air system. This project will be completed by Phoenix Refrigeration. It will also be maintained and serviced by Phoenix Refrigeration and the Maintenance Director and/or designee on a routine basis to ensure compliance.	

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K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with mechanical ventilation. This deficient practice could affect 30 residents who reside on 400 Hall. Findings include: Based on observation with the maintenance supervisor on 02/19/13 at 9:20 a.m., the 400 Hall liquid oxygen storage room, where six full liquid oxygen containers were stored had a ceiling exhaust fan located in the center of the ceiling. Furthermore, the ceiling exhaust fan was not operational. Based on an interview with the maintenance supervisor on 02/19/13 at 9:30 a.m., the	K010143	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practiceThe exhaust fan was replaced by the Maintenance Director and is now fully operable.how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be takenAll residents have the potential to be affected by the alleged deficient practice. The exhaust fan was replaced by the Maintenance Director and is now fully operable. A facility inspection was completed, no other areas were identified as being affected by the alleged deficient practice.what measures will be put into place or what systemic changes will be made to ensure that the deficient practice	03/08/2013

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	liquid oxygen storage room is used for the storage of liquid oxygen and used as a transferring location by the nursing staff. The liquid oxygen storage room ceiling exhaust fan being inoperable was confirmed by the administrator at the exit conference on 02/19/13 at 2:00 p.m. 3.1-19(b)		does not recurRoutine rounds will be conducted by the Maintenance Director and/or designee to ensure compliance. Any areas identified during the rounds will be addressed timely by the Maintenance Director and/or designee.how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into placeThis will be monitored through the Environmental CQI tool which will be completed monthly for 6 months. This will be reviewed by the Quality Assurance Committee and any areas below 90% will have an action plan initiated. All areas identified with this tool will be addressed timely by the Maintenance Director and/or designee.	